true potential
health services inc.

Dr. Kahlen Pihowich ND
PH (306) 373-5209 | FAX (306) 373-5207
#3, 1810 – 8th Street East | Saskatoon, SK S7H 0T6
contact@truepotentialhealth.com | truepotentialhealth.com

PAIN / LASER INTAKE FORM

PERSONAL CONTACT INFORMATION

Our professional association requires us to maintain contact information for our patient records. No information will be provided to any other individual or group without your express permission. E-mail will only be used by our office to inform you of office events and will not be distributed for any other use.

Name: _____ Date: _____

Address:_____

City: _____ Province: _____ Postal Code:_____

Phone (cell): _____ (work): _____

Email address: _____ PHN (Sk. Health Card) # _____

Age: _____ Date of Birth: _____ Gender: _____ Education:_____

Occupation: _____ Employer:_____ Hours per week: _____

Marital Status:_____ Number of Children and their ages: _____

_____

Has any other family member already been a patient at this clinic? _____

Who can we thank for referring you? _____

Emergency contact: _____ Relationship: _____

Phone: _____

Address: _____

PHYSICIAN INFORMATION

Do you see a medical doctor? Y / N

Doctor's Name: _____Telephone: _____ Fax: _____

Have you previously been treated by a naturopathic doctor? Yes _____ No _____

Name _____ When? _____

Other health care practitioners you are seeing (including conventional and complementary practitioners):

1._____
2._____
3._____

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PRIMARY HEALTH CONCERNS

Please list, in order of importance, your primary health concerns/reasons for your visit	**Please indicate any current or previous treatments for the listed concerns and whether or not you found them effective**

Do you have any known contagious diseases at this time? Yes / No

If yes, what? _____

Do you have any known contagious diseases at this time? Yes / No

If yes, what? _____

Are you currently using any inhaled or oral corticosteroids? Yes / No

Are you currently receiving any cortisone injections? Yes / no

If yes, when was your last injection? _____

Are you currently pregnant? Yes / No

Do you currently have any active forms of Cancer ou are aware of? Yes / No

Do you have a pacemaker? Yes / No

Do you have an implanted CNS stimulator? Yes / No

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Informed Consent and Request for Naturopathic Medical Care and Laser Therapy

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Kahlen Pihowich, ND, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____, hereby request and consent to examination and treatment with naturopathic medicine and Laser treatment by Dr. Kahlen Pihowich, hereafter called allied health care provider. I can request that students and preceptors not be included in my evaluation and treatment.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Kahlen Pihowich:

1.) My suspected diagnosis(es) or condition(s)
2.) The nature, purpose, goals and potential benefits of the proposed care
3.) The inherent risks, complications, potential hazards or side effects of treatment or procedure
4.) The probability or likelihood of success
5.) Reasonable available alternatives to the proposed treatment procedure
6.) Potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a naturopathic evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Soft tissue and osseous manipulation (including naturopathic/osseous manipulation of the spine and extremities)
- Laser Therapy treatment with the K-Laser Platinum 1 device

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General Risks: Pain, discomfort, bruising, discoloration, burns, itching, soft tissue or bony injury from physical manipulation, aggravation of pre-existing symptoms.

Potential benefits: Relief from pain or other symptoms of disease, restoration of the body's normal function, assistance with injury and disease recovery, wound healing and increased blood flow, and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some therapies prescribed could present a risk to the pregnancy.

Notice to individuals with pacemakers, CNS implants and/or cancer: For your safety it is vital to alert your provider, Dr. Kahlen Pihowich, ND, of these conditions.

Notice to patients who receive cortisone injections: It is imperative, for your comfort and wellbeing, to inform Dr. Kahlen Pihowich, ND, of your most recent injection.

Please Initial:

☐ I understand that Dr. Kahlen Pihowich, ND, is currently not licensed to prescribe drugs or any controlled substances.

☐ I understand that Dr. Kahlen Pihowich, ND, is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

☐ I recognize that even the gentlest therapies may potentially have complications in certain conditions, in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns including the possibility of pregnancy, and all medications, including over the counter drugs (eg. Tylenol) and supplements.

I do not expect Dr. Kahlen Pihowich and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Pihowich explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

_____ _____
Printed Name of Patient Signature of Patient

_____ _____
Printed Name of Guardian Signature of Guardian

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Fee Schedule

First Laser Visit (20 minutes)	$105.00
Return Laser Visit (15 minutes)	$75.00

Lab work and supplements prescribed by Dr. Pihowich are an additional cost and not included in the visit fee.

Please note: Patient is responsible for payment at the time of service. A portion of your visit may be claimed through your extended health coverage, please check with your provider. We are happy to provide physical exams at no extra charge. All other testing is done at additional charge, please ask Dr. Pihowich for prices during your visit. You will be billed for phone consultations except those regarding problems or questions with prescribed treatments. ***Because fees are subject to change, please confirm at time of booking.***

Cancellation policy: Any appointments cancelled with less than 24 hours notice will be subject to a charge for the full cost of the missed visit.

I clearly understand that Dr. Pihowich is not a medical doctor, but a Naturopathic Doctor who practices with natural therapeutics.

Signed: _____ Date: _____